

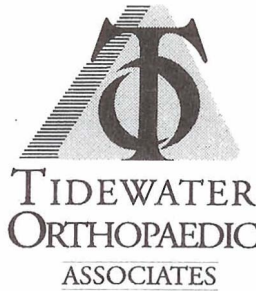
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Notice of Privacy Practice Receipt

I acknowledge that I was provided with the Notice of Privacy Practice for Tidewater Orthopaedics:

Print Name of Patient: _____

Signature of Patient: _____

Date: _____ **Social Security Number:** _____

Patient's Date of Birth: _____ **Phone Number:** _____

**Authorized Person (s) to Release Medical Information
(Spouse, children, friend, anyone we can release information to about you)**

Print Name of Personal Representative: _____

Social Security Number of Representative (last four digits): _____

Date: _____ **Phone Number:** _____

Print Name of Personal Representative: _____

Social Security Number of Representative (last four digits): _____

Date: _____ **Phone Number:** _____

Patient Refused to Sign Form: _____

Date: _____ **Signature of Practice Employee:** _____